The Power of Partnership:
Meeting Today's MCH Challenges through Partnerships
MCH Training Program

MCH Competencies Workgroup
October 5–6, 2004

MCHB Representative: Madhavi Reddy, MSPH
Facilitators: Arden Handler, Dr.P.H., MPH; Sally Stuart, MSW; and Mark Brown, MD

Other Participants:

Mary Barger	Karen Edwards	Julie McDougal
Gigliola Baruffi	Jose Gorrin Peralta	Marcia Roth
Linda Bearinger	Dennis Harper	Bruce Shapiro
Craig Becker	David Helm	Nimi Singh
Mark Brown	Stephen Hooper	Lann Thompson
Crystal Clement	Marily Krajicek	Randi Henderson
Kay Conklin	Teresa Marchese	(Recorder)

Tasks

As outlined in the National MCH Training Strategic Plan, MCHB is interested in supporting the development of MCH competencies for 2 audiences: MCH students and practicing MCH professionals.

- What is meant by "core MCH competencies" and how would these differ from or complement disciplinary competencies?
- What MCH competencies already exist, and how can we build upon them?
- What is the process for developing them?
- How do programs prepare trainees for achieving core competencies and how are outcomes from training reflected in leadership competencies after graduation?
- How should the draft competencies be tested or evaluated?

Competency encompasses knowledge, skills, and attitude and enables effective performance. Competency in MCH implies standards in a number of content areas: The competencies must be evolving and reflect dynamic needs and priorities in a practice and research environment.

- Science;
- Management;
- Communication;
- Policy/advocacy;
- Methods/analysis;
- Values/ethics;
- Provide basis for curriculum/continuing education.

The group will divide into three subgroups, which will then have an hour and a half for discussion. Each subgroup will consider the entire topic.

Welcoming Remarks

At this meeting workgroup members are expected to lay the groundwork for the development of competencies. It is expected that the work of the group will continue until early 2006. Group members will come together in various settings, including conference calls and listservs, and will decide on the specifics of those procedures after the discussions today and tomorrow. By early 2006, there should be a set of competencies that reflect the input of all of the MCH training programs. Adoption and achievement of these competencies should ultimately increase the number of practitioners who demonstrate expertise in MCH, including proficiency in public health. Most, if not all, of the training programs represented by workgroup members probably have worked on discipline-specific competencies. The work of this group should not be to replace these competencies, but to develop core MCH competencies that are cross-cutting and applicable to all MCH professionals.

To preserve MCH in institutions of higher learning, training individuals with the potential to become leaders in their respective fields is essential. This motivation sets the MCH training program apart from most of the workforce development programs funded by the Bureau of Health Professions. While planning this workgroup, there was discussion about whether the MCH Competencies and Leadership Competencies workgroups should be combined. It is logical to assume that if a set of core MCH competencies is created, students who show proficiencies in these competencies at graduation will be the ones most likely to show proficiency in leadership competencies 5 to 10 years after graduation. But, the MCH competencies, upon achievement, should be seen as set of training competencies that will permit MCH professionals to perform essential services within the context of the functions of their disciplines. Leadership competencies should allow MCH professionals to move beyond excellent clinical or health administration practice to leadership through practice, research, teaching, administration, and advocacy. Proficiency in these competency areas should illustrate the “ultimate” MCH professional once he or she has had the opportunity to build upon the core MCH competencies he or she achieved during training.

The main background document for the workgroup was the Association of Teachers of Maternal and Child Health (ATMCH) competencies. These competencies are essential for MCH professionals because they address MCH and general public health content in core areas such as the scientific basis of MCH and public health, methodological/analytical skills, management and communications skills, policy and advocacy skills, and values and ethics in MCH public health practice. The competencies have been developed with various constituencies in mind. The workgroup should begin with what is meant by “core MCH competencies” and whether the ATMCH competencies are a framework for them, and how competencies for clinical professionals can be integrated into the existing MCH competencies.

The workgroup should look at the processes used to create the competencies that already exist and also consider how the group might have to modify these processes to meet the expectation of this collaborative endeavor, with all the training programs at the table. Representatives from

Leadership Education in Adolescent Health (LEAH), Leadership Education in Neurodevelopmental and Related Disabilities (LEND), Pediatric Pulmonary Centers (PPC), Schools of Public Health (SPH) and Leadership Education in Research and Nursing (LERN) are all in the workgroup, so more than one perspective will be heard.

Full Workgroup Discussion

Points made included:

- Dr. Handler said that with ATMCH competencies and other lists of competencies, the Bureau wants to see what MCH Competencies all training grants can have in common, with the purpose to ensure that every training grant has some population focus. Some confusion arose with the distinction between this group's work and the work on leadership competencies that occurred at the Seattle Conference in April 2004. Core competencies were conceptualized as leading to leadership competencies. ATMCH competencies were developed in the early 90s and were meant to guide public health training. These competencies are used to design curriculum, evaluate curriculum, and develop graduate education programs and work force training programs. They are divided into five areas—scientific basis, methologic/analytic skills, management and communication skills, policy and advocacy skills, and values and ethics in MCH public health practice.
- The competencies to be developed here are not curricula goals, but what can be expected of trainees when they graduate.
- This process will not determine specifically what to teach at master's and doctoral levels, but it can inform curricula decisions.

Discussion Groups

Group 1

Arden Handler	Marcia Roth
Heidi Feldman	Dennis Harper
Loretta Fuddy	Colleen Monahan
Correy Robinson	Guy Lotrecchiano
Michele Gains	Julie McDougal

One participant asked if competencies should be conceptualized to target the population of students getting degrees. Dr. Handler said that most people in this subgroup are not from schools of public health, and the idea is to think across programs, and people going in and out of programs. This task is not just about training grants. Participants should think beyond funding to the broader field.

To a question about whether there is any interest in levels within a competency or different groups of competencies in training versus practice, Dr. Handler responded that those considerations will come later. This task is to establish basic common competencies.

Michele Gains noted that students may be younger than graduate level, and some should be targeted in high school and college, so that recruitment can be addressed. In response to a question about whether the competencies to be developed are complementary to the core public health competencies or will replace them, Dr. Handler said it depends on what the workgroup decides. There are things specific to MCH that might not be included in core public health competencies. Adoption of MCH competencies is to ensure that everyone in a MCH Training Program is not starting from scratch.

Marcia Roth asked how our MCH training grants contribute to the achievement of the national performance measures developed by the Council on Linkages. The answer was that these are more general and the MCH competencies can be seen as a subset of the more general public health measures.
Three levels of achievement in a competency were suggested:

- Novice; has been exposed to competency, recognizes and understands
- Competent/proficient; can describe, evaluate
- Expert; teaches, organizes curriculum, supervises program

Michele Gains noted that the levels used by the Council of Linkages wouldn't work for this group, because it involves students. Heidi Feldman suggested more detail in the description, with another column for students, and that brief training with senior personnel would be useful.

The workgroup expressed general disagreement with the Linkages categories. In terms of applying competencies to the real world, the more multidimensional they are, the more difficult the process. Staff members should achieve a certain level of competencies, but a question is how to work across disciplines. Most people come to MCH with a specific discipline and they have a certain set of competencies, and there was a question how that works when MCH competencies are put on top of that. What is needed is translation, to go from a set of skills to how they can be used in a population-based public health context. Then leadership competences are the outputs of core MCH competencies. More graphically:

Discipline → MCH → leadership

To illustrate, the subgroup chose a concrete topic and discussed how competencies would be different in the categories. Using epidemiology as an example:

- At the discipline level, know something about epidemiology;
- For MCH, know the epidemiology of women and children health care needs;
- At the leadership level, be able to translate knowledge into policy.

The Leadership Workgroup is creating its own separate list of competencies in isolation from this subgroup. In one model, MCH and leadership competencies can be conceptualized as bi-directional arrows. Another model features separate circles for discipline, MCH, and leadership, with arrows between the circles. A third graphic model locates discipline competencies as the platform on which MCH and leadership competencies rest. The idea is to move more people with discipline-specific knowledge to leadership, i.e., to see if people with clinical skills can have a greater impact if they move toward leadership and policymaking. People are fluid, and some may

not have a discipline at all. The competencies help clarify how to train people. Some participants felt that just using general public health competencies is not appropriate—but most felt that MCH competencies should build from public health competencies and be compatible with them.

Other Suggestions and Discussion Points:

- Distill out ATMCH competencies;
- Competency is a lifetime trajectory;
- Basic MCH competencies should be short and simple, with overarching values;
- National performance standards are not set for specialties; each discipline has to address how to meet common performance measures;
- A section on values and ethics must be simplified so that people can articulate a set of values that guide MCH programs;
- If competencies are to be applied to everyone who receives training, they must remain simple. A starting point could be MCH core values, and then groups could be more specific related to their disciplines.
- Levels of competencies (novice, proficient, expert) go across the various levels of training and imply a skill set;
- Competencies should be targeted at people who are aiming to be MCH professionals (e.g., long-term trainees rather than an individual who might just be attending a CE workshop put on by the training grant);
- Cultural competency as a value should be integrated in some way. But cultural competence is not unique to MCH.
- Competencies can't be too specific because they must apply to different activities, but there is a core set that could be nationally implemented, no matter what the discipline or activity.
- It is important to address disparities in training; it is often overlooked in training programs.

The subgroup decided on a number of major headings to serve as a framework for considering competencies:

- Values; access to family care
- Historical and legislative basis, i.e., the MCH pyramid, essential services, performance measures, title V legislation, LEND history, WIC history, etc.
- MCH related delivery systems: systems that serve women, children, and families—how to use them, carve-out issues, etc.
- Social determinants of MCH health status, a social ecological model that looks at family, schools, social programs, legislation, etc.
- Scientific basis, which includes epidemiology, genetic health behavior, growth and development, life cycle.

Four (rather than the three described above) competency levels were suggested as an alternative construct:

- Novice—recognize, understand, is aware
- Competent—list, identify, discuss
- Proficient—applies, integrates, evaluates, advocate at individual level

- Expert—teaches, designs programs, evaluates programs, effects policy, advocates at system level

Reporting Back—Day 2

The session began with reports on yesterday's discussions in the subgroups.

Group 2

Mark Brown	Lisa Samson-Fang	Karen Edwards
Steve Contonpasis	Crystal Clement	Gigliola Baruffi
Lann Thompson	Jose Gorrin-Peralta	

Dr. Brown presented for this subgroup. The group concluded that some core competencies related to mastery of content and process are not readily measurable. The one general content core competency everyone agreed on for all MCH programs was "MCH 101"—factual information about the legislative basis for MCH, history, structure, and funding basis, i.e., who supports Title V. Discipline competencies differ from core competencies.

Three levels of competency were described:
1. Novice; simple awareness
2. Proficiency; knowledge
3. Expert; skills

As a process for developing competencies, the subgroup proposed that the group take what exists in descriptions of competencies—i.e., PH, PPC, MCH, ATMCH, some residency programs—and consolidate them, reference where each competency came from, redevelop the content as necessary, and apply it to MCH training. They discussed the philosophical issue of whether, in preparing trainees, trainers can instill passion and commitment for the values of MCH, or if trainees must come to the program with this passion. To instill the passion, it is necessary to show relevance of the competencies to day-to day-lives and the impact it has on patients.

The subgroup listed five aspects of preparing trainees to achieve competencies:
1. Evaluate portfolio during training.
2. Evaluation of trainees' documentation.
3. Mentor's evaluation/opinion. Trainees should also be evaluated after they have been in practice; that evaluation is likely to be more performance-based than knowledge-based. Mentors and then supervisors can be asked if behaviors reflecting the competencies were seen in trainees/employees. Followup of 1.5 to 10 years of trainees and supervisors was suggested.
4. Incentive, for example, loan forgiveness.
5. Methods of training, for example:
    - Case-based
    - Didactic
    - Practicum
    - Experiential

Group 3

Mary Barger	David Helm	Bruce Shapiro
Linda Bearinger	Stephen Hooper	Nimi Singh
Craig Becker	Marilyn Krajicek	Sally Stuart
Kay Conklin	Teresa Marchese	Others

Three themes continued through the discussion: (1) leadership; (2) the interdisciplinary nature of MCH programs, which implies the need to inculcate collaboration and problem-solving; and (3) training for professional expertise.

The group defined a competency as something expected from all graduates of a program. In considering whether to use what already exists, there was strong advocacy for ATMCH. Another model is used in graduate medical education; this addresses content areas of communication, knowledge, technical skills, professionalism, systems-based practice, and practice-based application. When considering how these areas map to the ATMCH competencies, the group determined that they map closely. They discussed the Seattle competencies and listed areas that competencies should cover:

- Title V—legislation and national approach to care
- Interdisciplinary—multiple approaches to care and systems development
- Application of evidence-based research, skills, and best practice
- Needs assessment
- Strategic planning
- Program evaluation
- Research projects
- Advocacy, including educating legislators
- Values
- Communication, including cross-discipline, cross-program, cross-culture, spoken and written, consensus building, conflict resolution, and problem-solving
- Professionalism
    - Family-centered
    - Ethics
    - Licensure and certification
    - Lifelong learning
- Family-centered, involving family dynamics, service provision, family and rest of system, and primacy of family

Specifics of these competencies would differ from program to program. Many programs have multiple trainees at multiple levels for varying durations. The group recognizes that there will be different levels of competency and that there is not a single definition of competency.

As a final task, the subgroup took 6 or 7 core competency themes and mapped them on a pyramid, to attempt to discern what competencies are needed at different points on the pyramid.

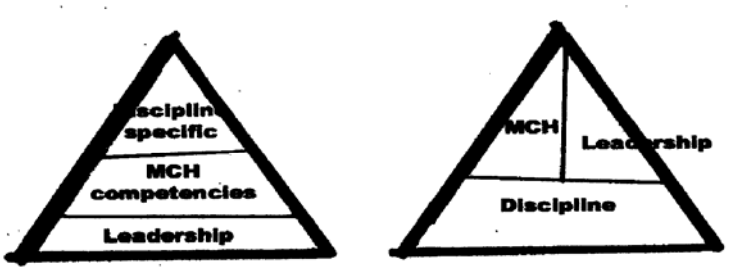
This is directed toward deriving a common language for different parts of the MCH family, and also applies to staff recruitment and training.

Group 1

Dr. Handler reported for Group 1. (The previous section of this report on Subgroup 1 deliberations covers this group's discussions in greater detail.)

Early in its process, the subgroup considered to whom competencies should apply. The conclusion was that competencies are for the emerging and existing MCH professional, but also have implications for larger workforce and for those emerging into the workforce.

In trying to determine conceptual frameworks about how different perspectives relate, the group came up two possible triangles. The first had leadership at the base, MCH competency in the middle, and specific disciplines at the top. The second had MCH and leadership resting on a broad base of the specific disciplines.



One question is, does discipline plus core competencies plus leadership equal leaders, or does discipline plus core competencies equal leadership?

The group then elaborated on topic areas for core competencies:

- Values/ethics
- History and legislative base
- MCH related delivery systems
- Social determinants of MCH health status
- Scientific basis

There was some discussion whether analytic skills should be core competencies or leadership competencies, and consultation with the leadership group is needed on this.

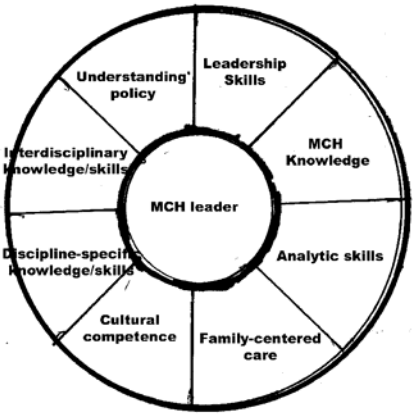
After discussion, the subgroup decided to expand the three levels of competency to four:

- Novice
- Competent
- Proficient
- Expert

A participant from another subgroup was wary of using the term "expert" and suggested other language for levels: beginning, developed, and advanced.

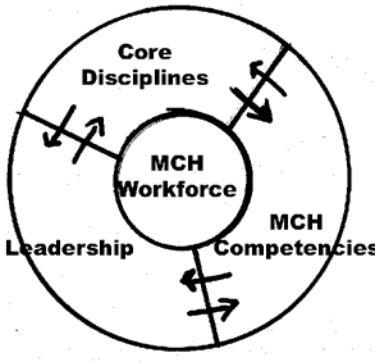
General Discussion

Several group members offered other graphical renderings of what the inter-relationships could be with competencies. The first was described as a mandala (a circular design containing concentric geometric forms, symbolizing the continuity of the universe). In the center is a small circle with the MCH leader, and in eight surrounding pizza-like slices are leadership skills; MCH knowledge of history, policy, planning and measurement systems; analytical skills; family centered care; cultural competence; discipline-specific knowledge and skills; interdisciplinary knowledge and skills; understanding policy across systems, world, national, state, community. Ethics and professional standards go in the MCH knowledge slice.



Another suggestion looks something like a spider web, three concentric circles divided by triangular slices. The inner circle represents the individual discipline, the middle circle is MCH, and the outer circle is leadership. Each slice is a stream that runs through, such as communications, policy systems, and ethics. The competent leader develops first within his or her discipline and must master the discipline, then move on to MCH, then to the broader circle of leadership. This also illustrates the interface between leadership and other areas such as communication and policy.

Another simpler model features relationships in concentric circles that are bi-directional, allowing events that occur later in leadership development to feed back, to form an individual's personal identity. MCH competencies/social strategies, leadership/policy, and core discipline all work interactively in a circular way to create a competent MCH workforce.



Leadership is probably the weakest facet for MCH. One participant remarked that this model would not stand alone and crosscutting competencies that augment it also need to be described. Communication skills have a role in all models, and leadership features greater communication skills.

In other comments about the graphic representations, participants noted that leadership is a developmental process, and people do not usually start out in their careers with the goal of being a leader and that all the components continue to evolve.

Commonalities in models were then described. All of the models included core MCH issues, leadership, and disciplines. Key concepts of all models were that they are interactive, dynamic, developmental, and integrative.

A number of participants again expressed concern about the overlap of the work of this group and the leadership group, and that the work would need to be integrated. Dr. Handler and Ms. Reddy said that the MCHB staff would bring different pieces together as necessary. Further development of a conceptual framework will be one of the group's action steps. Specifically, a number of aspects need to be addressed:

- Specific MCH competencies still need to be spelled out.
- Gaps and overlap in the pieces of the framework need to be identified.

When the pediatric pulmonary centers developed competencies, they created large lists with input from all parties that were then narrowed using a modified Delphi Technique, with items adopted with 80 percent consensus. This allowed people to change their opinion based on input from others, and at the end of several months, the product was something everyone accepted.

Others felt that the target population for the competencies needs to be more clearly defined. Ms. Reddy said that the Bureau is looking at both MCH trainees and the MCH professional community. Dr. Shapiro added that programs could put their own individual emphases on the competencies. Dr. Handler said that one of the outcomes of developing competencies would be the public health training programs becoming more aware of the clinical perspective, and the clinical training programs taking a more population-wide perspective.

Further discussion considered how competencies would be evaluated, and the relation to discipline-specific evaluation. The need to develop competencies in the context of what already exists was emphasized, and to assess how the new competencies relate to extant ones.

Summary Points:

- Competencies are dynamic, developmental, integrated skill/knowledge sets and attitudes.
- There are several conceptual frameworks/models that describe the integration of areas of competency.
- Core competencies are those that are applicable to all training programs and that are to be expected of any MCH program graduate, to varying degrees depending on program discipline and trainees' educational expectations, base, goals, and length of program. Competency is also about how MCH systems work, for example, what are the relevant principles of Healthy People 2010? People need to know what Title V is and how it was derived from the Children's Bureau, as well as attitudes, practices, and medical grounding of MCH.
- There is a need for integration of competencies from other workgroups, particularly the leadership group, to make sure all are moving in the same direction. Competencies considered by the leadership group, which were based on the Seattle meeting, were circulated and discussed.

Action Items:

- Communicate with other MCH working groups developing competencies.
- Develop common language. Assemble and agree on a glossary of terms/definitions to assure accurate, clear communication.
- Meet or communicate with stakeholders (end users of products). The group has to decide who the stakeholders are.
- Develop conceptual framework with stakeholders.
- Inventory existing core curricula for commonalities in how they teach competencies.
- Identify the core competencies. Decide upon the critical mass of MCH 101, at different levels. This can be a knowledge base or it can be applied knowledge.

One issue was identified as a parking lot item, to be considered further along in the process:

- What is the relevance of MCH competencies to real-world practice?